Medical History / VSP Questionnaire

Name _____**DOB** _____**Date** _____

Medications

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Drug Allergies: _____

Preferred Pharmacy: _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Y / N	Nervous	Y / N	Endocrine (glands)	Y / N
Ears/Nose/Throat	Y / N	Urinary	Y / N	Blood/Lymph	Y / N
Cardiovascular	Y / N	Muscles/Bones	Y / N	Allergic/Immunologic	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Headaches	Y / N
High Blood Pressure	Y / N	Eyes	Y / N	Mental	Y / N

Please explain_____

Diabetes Yes/No Type _____ Date of diagnosis_____

Other health problems_____

Have you had any operations? Y /N Kind? _____ When? _____

Name of family doctor_____

Date of last visit_____ Date of last tetanus shot _____

Family History

High blood pressure Y / N Relation _____ Macular degeneration Y / N Relation_____
Diabetes Y / N Relation _____ Retinal detachment Y / N Relation_____
Glaucoma Y / N Relation _____ Cataracts Y / N Relation_____

Personal Eye Information

Do you have any eye conditions or problems? Y / N What kind? _____
Have you had any eye operations? Y / N Type_____ Date _____
Have you had an eye injury? Y / N Kind? _____ Date _____
Do you have glaucoma? Y / N Cataracts? Y / N Dry eyes? Y /N
Macular degeneration? Y / N Retinal detachment? Y / N Blurred vision? Y / N
Do you wear glasses? Y / N Contact lenses? Y / N Type _____
Additional information
_____